

**North Carolina Department of Health and Human Services**  
**Division of Public Health • Epidemiology Section**  
**Communicable Disease Branch**

**ATTENTION HEALTH CARE PROVIDERS:**

Please report relevant clinical findings about this disease event to the local health department.

**TYPHOID FEVER, ACUTE**  
**Confidential Communicable Disease Report—Part 2**  
**NC DISEASE CODE: 44**

**REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.**

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /	SSN
---------------------	-------	--------	--------	--------------	-------	-------------------------------	-----



**NC EDSS  
LAB RESULTS**

Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	



**NC EDSS PART 2 WIZARD  
COMMUNICABLE DISEASE**

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U

If yes, symptom onset date (mm/dd/yyyy): \_/ \_/ \_

CHECK ALL THAT APPLY:

Fever ☐ Y ☐ N ☐ U

- ☐ Yes, subjective ☐ No  
☐ Yes, measured ☐ Unknown

Highest measured temperature \_\_\_\_\_

Fever onset date (mm/dd/yyyy): \_\_\_\_\_

Fatigue or malaise or weakness ☐ Y ☐ N ☐ U

Loss of appetite (anorexia) ☐ Y ☐ N ☐ U

Altered mental status ☐ Y ☐ N ☐ U

Sweats (diaphoresis) ☐ Y ☐ N ☐ U

Night sweats ☐ Y ☐ N ☐ U

Headache ☐ Y ☐ N ☐ U

Cough ☐ Y ☐ N ☐ U

Onset date (mm/dd/yyyy): \_\_\_\_\_

Productive ☐ Y ☐ N ☐ U

Enlarged spleen (splenomegaly) ☐ Y ☐ N ☐ U

Rose spots ☐ Y ☐ N ☐ U

Parotitis ☐ Y ☐ N ☐ U

Constipation ☐ Y ☐ N ☐ U

Partial hearing loss ☐ Y ☐ N ☐ U

Abdominal pain or cramps ☐ Y ☐ N ☐ U

Diarrhea ☐ Y ☐ N ☐ U

Describe (select all that apply)

- ☐ Bloody ☐ Non-bloody  
☐ Watery ☐ Other

Maximum number of stools in a 24-hour period: \_\_\_\_\_

During the 60 days prior to onset of symptoms, was the patient:

Employed as food worker? ☐ Y ☐ N ☐ U

Where employed? \_\_\_\_\_

Specify job duties: \_\_\_\_\_

What dates did the patient work? \_\_\_\_\_

During the 60 days prior to onset of symptoms, was the patient: Employed as food worker while symptomatic? ☐ Y ☐ N ☐ U

Where did the patient work? \_\_\_\_\_

What dates did the patient work? \_\_\_\_\_

What day did the patient return to food service work?

Date: \_\_\_\_\_

Where did patient return to work? \_\_\_\_\_

A non-occupational food worker?

(e.g. potlucks, receptions) during contagious period ☐ Y ☐ N ☐ U

Where employed? \_\_\_\_\_

Specify dates worked during contagious period: \_\_\_\_\_

A health care worker or child care worker

handling food or medication in the contagious period? ☐ Y ☐ N ☐ U

Where employed? \_\_\_\_\_

Specify dates worked during contagious period: \_\_\_\_\_

Comments: \_\_\_\_\_

**PREDISPOSING CONDITIONS**

Any immunosuppressive conditions ☐ Y ☐ N ☐ U

Please specify: \_\_\_\_\_

Previously known typhoid carrier ☐ Y ☐ N ☐ U

Other underlying illness ☐ Y ☐ N ☐ U

Specify: \_\_\_\_\_

Receiving treatment or taking any medications ☐ Y ☐ N ☐ U

☐ Immunosuppressive therapy, including anti-rejection therapy

Specify \_\_\_\_\_

Was medication taken/therapy provided within the last 30 days before this illness? ☐ Y ☐ N ☐ U

For what medical condition? \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Specify \_\_\_\_\_

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

### HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U

Hospital name: \_\_\_\_\_

City, State: \_\_\_\_\_

Hospital contact name: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Admit date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Discharge date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

### ISOLATION/QUARANTINE/CONTROL MEASURES

**Restrictions to movement or freedom of action?** ☐ Y ☐ N

Check all that apply:

☐ Work ☐ Sexual behavior

☐ Child care ☐ Blood and body fluid

☐ School ☐ Other, specify \_\_\_\_\_

Date control measures issued: \_\_\_\_\_

Date control measures ended: \_\_\_\_\_

Was patient compliant with control measures? ☐ Y ☐ N

**Did local health director or designee implement additional control measures?** (example: cohort classrooms, special cleaning, active surveillance, etc.) ☐ Y ☐ N

If yes, specify: \_\_\_\_\_

**Were written isolation orders issued?** ☐ Y ☐ N

If yes, where was the patient isolated? \_\_\_\_\_

Date isolation started? \_\_\_\_\_

Date isolation ended? \_\_\_\_\_

Was the patient compliant with isolation? ☐ Y ☐ N

### CLINICAL OUTCOMES

Discharge/Final diagnosis: \_\_\_\_\_

Survived? ☐ Y ☐ N ☐ U

Died? ☐ Y ☐ N ☐ U

Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

### TRAVEL/IMMIGRATION

**The patient is:**

☐ Resident of NC

☐ Resident of another state or US territory

☐ Foreign Visitor

☐ Refugee

☐ Recent Immigrant

☐ Foreign Adoptee

☐ None of the above

**Did patient have a travel history during the 60 days prior to onset of symptoms?** ☐ Y ☐ N ☐ U

List travel dates and destinations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Does patient know anyone else with similar symptom(s) who had the same or similar travel history?** ☐ Y ☐ N ☐ U

List persons and contact information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Additional travel/residency information:**

### CHILD CARE/SCHOOL/COLLEGE

**Patient in child care?** ☐ Y ☐ N ☐ U

**Patient a child care worker or volunteer in child care?** ☐ Y ☐ N ☐ U

**Patient a parent or primary caregiver of a child in child care?** ☐ Y ☐ N ☐ U

**Is patient a student?** ☐ Y ☐ N ☐ U

Type of school: \_\_\_\_\_

**Is patient a school WORKER / VOLUNTEER in NC school setting?** ☐ Y ☐ N ☐ U

Give details: \_\_\_\_\_

### BEHAVIORAL RISK & CONGREGATE LIVING

**During the 60 days prior to onset of symptoms did the patient live in any congregate living facilities** (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? ☐ Y ☐ N ☐ U

Name of facility: \_\_\_\_\_

Dates of contact: \_\_\_\_\_

**During the 60 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings?** ☐ Y ☐ N ☐ U

If yes, specify: \_\_\_\_\_

**In what setting was the patient most likely exposed?**

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility / Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/ Detention Center	

**During the 60 days prior to onset, did the patient have sexual contact with a known carrier of this disease?** ☐ Y ☐ N ☐ U

Did the partner(s) become ill with the same symptoms? ☐ Y ☐ N ☐ U

**Since disease onset, has the patient had sexual contact with other(s)?** ☐ Y ☐ N ☐ U

Did the partner(s) become ill with the same symptoms? ☐ Y ☐ N ☐ U

### HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

**During the 60 days prior to onset of symptoms, did the patient work or volunteer in a health care or clinical setting?** ☐ Y ☐ N ☐ U

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Occupation:

☐ Physician

☐ Physician's assistant or nurse practitioner

☐ Nurse

☐ Laboratory

☐ Other \_\_\_\_\_

☐ Unknown

Specify work setting or volunteer duties \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### OTHER EXPOSURE INFORMATION

**Does the patient know anyone else with similar symptoms?** ☐ Y ☐ N ☐ U

If yes, specify: \_\_\_\_\_

**During the 60 days prior to onset of symptoms did the patient have contact with sewage or human excreta?** ☐ Y ☐ N ☐ U

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

## FOOD RISK AND EXPOSURE

During the 60 days prior to onset of symptoms, did the patient eat any raw or undercooked meat or poultry? ☐ Y ☐ N ☐ U

Specify meat/poultry: \_\_\_\_\_

Specify place of exposure: \_\_\_\_\_

During the 60 days prior to onset of symptoms did the patient eat any raw or undercooked seafood or shellfish (i.e., raw oysters, sushi, etc.)? ☐ Y ☐ N ☐ U

Specify type of seafood/shellfish: \_\_\_\_\_

Specify place of exposure: \_\_\_\_\_

Describe the source of drinking water used in the patient's home (check all that apply):

- ☐ Bottled water supplied by a company  
☐ Bottled water purchased from a grocery store  
☐ Municipal supply (city water)  
☐ Well water

Does the patient have a water softener or water filter installed inside the house to treat their water? ☐ Y ☐ N ☐ U

During the 60 days prior to onset of symptoms, did the patient drink any bottled water? ☐ Y ☐ N ☐ U

Specify type/brand: \_\_\_\_\_

Where does the patient/patient's family typically buy groceries?

Store name: \_\_\_\_\_

Store city: \_\_\_\_\_

Shopping center name/address: \_\_\_\_\_

During the 60 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? ☐ Y ☐ N ☐ U

Specify source: \_\_\_\_\_

Eat any food items that came from a store or vendor where they do not typically shop for groceries? ☐ Y ☐ N ☐ U

Specify source(s): \_\_\_\_\_

Drink unpasteurized milk? ☐ Y ☐ N ☐ U

Specify type of milk:

- ☐ Cow  
☐ Goat  
☐ Sheep  
☐ Other, specify: \_\_\_\_\_  
☐ Unknown

Eat any other unpasteurized dairy products? ☐ Y ☐ N ☐ U

Specify type of product:

- ☐ Queso fresco, Queso blanco or other Mexican soft cheese  
☐ Butter  
☐ Cheese from raw milk, specify: \_\_\_\_\_  
☐ Food made from raw dairy product, specify: \_\_\_\_\_  
☐ Other, specify: \_\_\_\_\_

Drink unpasteurized juices or ciders? ☐ Y ☐ N ☐ U

Specify juices or ciders:

- ☐ Apple  
☐ Orange  
☐ Other, specify: \_\_\_\_\_

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)? ☐ Y ☐ N ☐ U

Eat raw fruit? ☐ Y ☐ N ☐ U

Specify raw fruit:

- ☐ Apples  
☐ Bananas  
☐ Oranges

- ☐ Grapes, specify: \_\_\_\_\_  
☐ Pears  
☐ Peaches  
☐ Berries, specify: \_\_\_\_\_  
☐ Melon, specify: \_\_\_\_\_  
☐ Mangoes  
☐ Other, specify: \_\_\_\_\_

Eat raw salads or vegetables other than sprouts? ☐ Y ☐ N ☐ U

Specify raw salad or vegetable:

- ☐ Bagged salad greens without toppings, type: \_\_\_\_\_  
☐ Salad with toppings, specify: \_\_\_\_\_  
☐ Lettuce, type: \_\_\_\_\_  
☐ Spinach  
☐ Tomatoes, type: \_\_\_\_\_  
☐ Cucumbers  
☐ Mushrooms, type: \_\_\_\_\_  
☐ Onions, type: \_\_\_\_\_  
☐ Potatoes, type: \_\_\_\_\_  
☐ Other, specify: \_\_\_\_\_

Eat sprouts? ☐ Y ☐ N ☐ U

Specify type of sprouts:

- ☐ Alfalfa ☐ Clover ☐ Bean  
☐ Other, specify: \_\_\_\_\_  
☐ Unknown

Eat fresh herbs? ☐ Y ☐ N ☐ U

Specify:

- ☐ Basil ☐ Thyme  
☐ Parsley ☐ Cilantro  
☐ Oregano ☐ Rosemary  
☐ Cumin  
☐ Other, specify: \_\_\_\_\_

Eat potentially hazardous foods (i.e. pastries, custards, salad dressings)? ☐ Y ☐ N ☐ U

Specify:

- ☐ Pastries  
☐ Custards  
☐ Salad dressings  
☐ Other, specify: \_\_\_\_\_

Eat commercially-prepared, refrigerated foods (i.e. dips, salsa, sandwiches)? ☐ Y ☐ N ☐ U

Specify type of food:

- ☐ Dips, specify: \_\_\_\_\_  
☐ Salsa  
☐ Sandwiches, Specify: \_\_\_\_\_  
☐ Other, Specify: \_\_\_\_\_

Eat at a group meal? ☐ Y ☐ N ☐ U

Specify:

- ☐ Place of Worship  
☐ School:  
☐ Social function  
☐ Other, Specify: \_\_\_\_\_

Eat food from a restaurant? ☐ Y ☐ N ☐ U

Name: \_\_\_\_\_

Location: \_\_\_\_\_

Did the patient ingest breast milk? ☐ Y ☐ N ☐ U

Source of milk: \_\_\_\_\_

Did the patient ingest infant formula? ☐ Y ☐ N ☐ U

Type: \_\_\_\_\_

Did the patient eat commercial baby food? ☐ Y ☐ N ☐ U

Type: \_\_\_\_\_

## CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed? \_\_\_\_\_

Were health care providers consulted? ☐ Y ☐ N ☐ U

Who was consulted? \_\_\_\_\_

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed: \_\_\_\_\_

Notes on medical record verification: \_\_\_\_\_

## GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

- ☐ In NC  
City \_\_\_\_\_  
County \_\_\_\_\_  
☐ Outside NC, but within US  
City \_\_\_\_\_  
State \_\_\_\_\_  
County \_\_\_\_\_  
☐ Outside US  
City \_\_\_\_\_  
Country \_\_\_\_\_  
☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes regarding setting of exposure: \_\_\_\_\_

## VACCINE

Has patient / contact ever received vaccine related to this disease? ☐ Y ☐ N ☐ U

Vaccine type: \_\_\_\_\_

Date last dose received (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Source of vaccine information:

- ☐ Patient's or Parent's verbal report  
☐ Physician  
☐ Medical record  
☐ Certificate of immunization record  
☐ Patient vaccine record  
☐ School record  
☐ Other, specify: \_\_\_\_\_  
☐ Unknown

## **Typhoid Fever (*Salmonella typhi*)**

### **1997 CDC Case Definition**

#### **Clinical description**

An illness caused by *Salmonella typhi* that is often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and nonproductive cough. However, many mild and atypical infections occur. Carriage of *S. typhi* may be prolonged.

#### **Laboratory criteria for diagnosis**

- Isolation of *S. typhi* from blood, stool, or other clinical specimen

#### **Case classification**

*Probable*: a clinically compatible case that is epidemiologically linked to a confirmed case in an outbreak

*Confirmed*: a clinically compatible case that is laboratory confirmed

#### **Comment**

Isolation of the organism is required for confirmation. Serologic evidence alone is not sufficient for diagnosis. Asymptomatic carriage should not be reported as typhoid fever. Isolates of *S. typhi* are reported to the Foodborne and Diarrheal Diseases Branch, Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC, through the Public Health Laboratory Information System.